

SEMINOLE COUNTY PUBLIC SCHOOLS
EARLY CHILDHOOD EDUCATION PRESCHOOL

LAKE BRANTLEY HIGH SCHOOL

DATE _____

PLEASE PRINT

STUDENT INFORMATION	STUDENT LEGAL NAME – LAST	FIRST	MIDDLE		
	NAME USED AT HOME	GENDER <input type="checkbox"/> MALE (M) <input type="checkbox"/> FEMALE (F)	AGE	BIRTHDATE (MO/DAY/YR) / / /	
	RESIDENTIAL ADDRESS – STREET NUMBER, NAME (DIRECTION)		APT. #	CITY	ZIP
	MAILING ADDRESS, if different from above		TELEPHONE NUMBER ()		
	<input type="checkbox"/> WHITE (W) <input type="checkbox"/> BLACK (B) <input type="checkbox"/> HISPANIC (H) <input type="checkbox"/> MULTI-RACIAL (M) <input type="checkbox"/> AMERICAN INDIAN (I) <input type="checkbox"/> ASIAN (A) <input type="checkbox"/> OTHER				

PARENT INFORMATION	STUDENT LIVES WITH:					
	<input type="checkbox"/> BOTH PARENTS		<input type="checkbox"/> MOTHER ONLY		<input type="checkbox"/> FATHER ONLY	
	<input type="checkbox"/> LEGAL GUARDIAN		<input type="checkbox"/> MOTHER & STEP-PARENT		<input type="checkbox"/> FATHER & STEP-PARENT	
	<input type="checkbox"/> GRANDPARENTS		<input type="checkbox"/> GRANDMOTHER ONLY		<input type="checkbox"/> GRANDFATHER ONLY	
	<input type="checkbox"/> OTHER					
	PARENT/GUARDIAN NAME	OCCUPATION	BUSINESS ADDRESS	BUSINESS TELEPHONE	HOME TELEPHONE	CELULAR/PAGER
	FATHER/GUARDIAN					
	MOTHER/GUARDIAN					
	HOME ADDRESS FATHER/GUARDIAN				CITY	ZIP
	HOME ADDRESS MOTHER/GUARDIAN					
E-MAIL ADDRESS FATHER/GUARDIAN						
E-MAIL ADDRESS MOTHER/GUARDIAN						
SIBLINGS: BROTHERS		AGE	SISTERS		AGE	

SECURITY INFORMATION	NOTE: CHILD WILL NOT BE RELEASED TO ANY ADULT (I.E., PARENTS, FRIENDS, NEIGHBORS, RELATIVES, COWORKERS, ETC.) OTHER THAN THOSE LISTED. (If appropriate, please be sure to list both parents.)			
	INDIVIDUAL(S) AUTHORIZED TO PICK UP STUDENT:			
	NAME (LAST, FIRST)	RELATION	TELEPHONE ()	CELULAR/ PAGER ()
	NAME (LAST, FIRST)	RELATION	TELEPHONE ()	CELULAR/ PAGER ()
	NAME (LAST, FIRST)	RELATION	TELEPHONE ()	CELULAR/ PAGER ()
	NAME (LAST, FIRST)	RELATION	TELEPHONE ()	CELULAR/ PAGER ()
	NAME (LAST, FIRST)	RELATION	TELEPHONE ()	CELULAR/ PAGER ()
VALID FLORIDA IDENTIFICATION MUST BE PRESENTED BEFORE THE STUDENT CAN BE RELEASED TO RESPONSIBLE PARTY				

PARENT/GUARDIAN SIGNATURE _____ DATE _____

SEMINOLE COUNTY PUBLIC SCHOOLS

EARLY CHILDHOOD EDUCATION PRESCHOOL

NAME OF SCHOOL

PLEASE PRINT

STUDENT _____ MALE FEMALE AGE _____
 LAST FIRST MIDDLE
 NAME USED AT HOME _____ DATE OF BIRTH ____/____/____
 HOME ADDRESS _____
 NUMBER AND STREET NAME APT. NUMBER CITY ZIP CODE

MEDICAL INFORMATION	PHYSICIAN'S NAME		PHYSICIAN'S ADDRESS		TELEPHONE ()
	DENTIST'S NAME		DENTIST'S ADDRESS		TELEPHONE ()
	ALLERGIES:		EYE GLASSES: <input type="checkbox"/> YES <input type="checkbox"/> NO		CONTACTS: <input type="checkbox"/> YES <input type="checkbox"/> NO
	FOOD ALLERGIES? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, please list foods				
	HOW DO YOU TREAT THESE ALLERGIES?				
	DOES YOUR CHILD EVER REFUSE TO EAT? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, please explain				
	DOES STUDENT HAVE ANY ILLNESS OR PHYSICAL CONDITION THAT REQUIRES SPECIAL CONSIDERATION AT SCHOOL? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, please identify				
	IS THERE ANY PREVIOUS MEDICAL HISTORY THAT WOULD AFFECT YOUR CHILD'S PARTICIPATION IN ACTIVITIES? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, please explain				
	DO YOU GIVE US PERMISSION TO CALL THE LOCAL HOSPITAL? <input type="checkbox"/> YES <input type="checkbox"/> NO				
	IF RECORDS LIST A NAME DIFFERENT FROM THE LEGAL NAME ABOVE, PLEASE SPECIFY THAT NAME:				
	IS STUDENT CURRENTLY TAKING MEDICATION DURING SCHOOL HOURS? <input type="checkbox"/> YES <input type="checkbox"/> NO			NAME OF MEDICATION/ PRESCRIPTION NUMBER:	
	AMOUNT TO BE GIVEN:			TIME TO BE GIVEN:	
	NO MEDICATION OF ANY KIND IS TO BE GIVEN TO A CHILD WITHOUT THE SIGNED PERMISSION OF THE PARTNE/GUARDIAN AND WRITTEN MEDICAL AUTHORIZATION FROM PHYSICIAN.				
	IN CASE OF AN EMERGENCY AND A PARENT CANNOT BE REACHED AT HOME OR WORK, CALL:				
	LAST NAME		FIRST NAME		RELATION
LAST NAME		FIRST NAME		RELATION	PHONE/CELULAR ()
LAST NAME		FIRST NAME		RELATION	PHONE/CELULAR ()
LAST NAME		FIRST NAME		RELATION	PHONE/CELULAR ()
LAST NAME		FIRST NAME		RELATION	PHONE/CELULAR ()

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In the event of serious accident or illness, I request the school to contact me. If I cannot be reached, the school may make the necessary arrangements to provide emergency care and treatment for my child. This may include conveyance to and treatment at a hospital or medical facility. I will assume responsibility of payment for services rendered.
 In the case of an accident or illness where immediate treatment of my child is not indicated, but where he/she is unable to remain in school, I request the school contact me or my spouse to arrange transportation of my child. If the school is unable to contact parent/legal guardian, I request that one of the persons listed on the this form be contacted and requested to care for my child.

PARENT/GUARDIAN SIGNATURE _____ DATE _____